Reprinted
February 27, 2002

ENGROSSED
HOUSE BILL No. 1163

DIGEST OF HB 1163 (Updated February 26, 2002 4:59 PM - DI 104)

Citations Affected: IC 27-8; noncode.

Synopsis: Waiver of preexisting conditions. Provides that an individual policy of accident and sickness insurance or a group policy of accident and sickness insurance under which a certificate of coverage is issued to an individual member of a non-employer based association or discretionary group may contain a waiver of coverage for a specified condition under certain circumstances. Requires the department of insurance to establish a list of waivers that may be contained in a policy. Specifies that an offer of coverage under a policy that includes a waiver does not preclude eligibility for a comprehensive health insurance association policy. Requires reporting by insurers to the department of insurance.

Effective: July 1, 2002.

Crooks, Adams T, Bischoff, Torr, Frizzell, Noe

(SENATE SPONSORS — JOHNSON, HUME, ANTICH)

January 9, 2002, read first time and referred to Committee on Insurance, Corporations and Small Business.
January 23, 2002, amended, reported — Do Pass.
January 29, 2002, read second time, amended, ordered engrossed.
January 30, 2002, engrossed. Read third time, passed. Yeas 77, nays 13.

SENATE ACTION

February 1, 2002, read first time and referred to Committee on Health and Provider Services.
February 21, 2002, amended, reported favorably — Do Pass.
February 26, 2002, read second time, amended, ordered engrossed.

Reprinted
February 27, 2002

Second Regular Session 112th General Assembly (2002)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2001 General Assembly.

ENGROSSED HOUSE BILL No. 1163

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 1. (a) The term "policy of accident and sickness insurance", as used in this chapter, includes any policy or contract covering one (1) or more of the kinds of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual basis under this section and sections 2 through 9 of this chapter, on the group basis under this section and sections 16 through ~~19~~ **19.2** of this chapter, on the franchise basis under this section and section 11 of this chapter, or on a blanket basis under section 15 of this chapter and (except as otherwise expressly provided in this chapter) shall be exclusively governed by this chapter.

(b) No policy of accident and sickness insurance may be issued or delivered to any person in this state, nor may any application, rider, or endorsement be used in connection with an accident and sickness insurance policy until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been

filed with the commissioner. This section is applicable also to assessment companies and fraternal benefit associations or societies.

(c) No policy of accident and sickness insurance may be issued, nor may any application, rider, or endorsement be used in connection with a policy of accident and sickness insurance, until the expiration of thirty (30) days after it has been filed under subsection (b), unless the commissioner gives his written approval to it before the expiration of the thirty (30) day period.

(d) The commissioner may, within thirty (30) days after the filing of any form under subsection (b), disapprove the form:

(1) if, in the case of an individual accident and sickness form, the benefits provided therein are unreasonable in relation to the premium charged; or

(2) if, in the case of an individual, blanket, or group accident and sickness form, it contains a provision or provisions that are unjust, unfair, inequitable, misleading, or deceptive or that encourage misrepresentation of the policy.

(e) If the commissioner notifies the insurer that filed a form that the form does not comply with this section, it is unlawful thereafter for the insurer to issue the form or use it in connection with any policy. In the notice given under this subsection, the commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer.

(f) The commissioner may at any time, after a hearing of which not less than twenty (20) days written notice has been given to the insurer, withdraw his approval of any form filed under subsection (b) on any of the grounds stated in this section. It is unlawful for the insurer to issue the form or use it in connection with any policy after the effective date of the withdrawal of approval. The notice of any hearing called under this subsection must specify the matters to be considered at the hearing, and any decision affirming disapproval or directing withdrawal of approval under this section must be in writing and must specify the reasons for the decision.

(g) Any order or decision of the commissioner under this section is subject to review under IC 4-21.5.

SECTION 2. IC 27-8-5-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy issued as an individual policy.

(5) A limited benefit health insurance policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

(b) The benefits provided by an individual policy of accident and sickness insurance may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.

(c) An individual policy of accident and sickness insurance may not define a preexisting condition, a rider, or an endorsement more restrictively than as:

(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of enrollment in the plan;

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of enrollment in the plan; or

(3) a pregnancy existing on the effective date of enrollment in the plan.

(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.

(e) Notwithstanding subsections (b) and (c), an individual policy of accident and sickness insurance may contain a waiver of coverage for a specified condition and complications that arise from the specified condition if:

(1) the period for which the exemption would be in effect does not exceed five (5) years; and

(2) all of the following conditions are met:

(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition, including a specific description of each condition, complication, service, and treatment for which coverage is being waived.

(B) The:

(i) offer of coverage; and

(ii) policy;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and specifying each related condition, complication, service, and treatment for which coverage is waived.

(C) The:

(i) offer of coverage; and

(ii) policy;

do not include more than two (2) waivers.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) The waiver of coverage does not apply to coverage required under state law.

(H) The waiver is included on the list of waivers established by the commissioner under subsection (i).

The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage and in the policy under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. The initialed written notice must be returned to the insurer before the insurer issues a policy that contains a waiver under this section. An offer of coverage under a policy that includes a waiver under this

subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.

(f) An insurer shall not, on the basis of a waiver contained in a policy as provided in subsection (e), deny coverage for any condition, complication, service, or treatment that is not specified as required in the:

(1) written notice under subsection (e)(2)(A); and

(2) offer of coverage and policy under subsection (e)(2)(B).

(g) An individual who is covered under a policy that includes a waiver under subsection (e) may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.

(h) Notwithstanding subsection (e), an individual policy of accident and sickness insurance may not contain a waiver of coverage for a mental health condition.

(i) The commissioner shall adopt rules under IC 4-22-2 to establish a list of waivers, based on a list of diagnostic and procedure codes (as described in IC 27-8-22.1-5(a)(1)), that may be contained in a policy under this section.

(j) A policy that contains a waiver under this section is presumed to provide coverage for a condition, complication, service, or treatment for which coverage is not specifically excluded under:

(1) a waiver under this section; or

(2) the terms of the policy.

SECTION 3. IC 27-8-5-19.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: **Sec. 19.2. (a) This section applies to a group policy of accident and sickness insurance:**

(1) that is not employer based;

(2) that covers the members of an association or discretionary group; and

(3) under which a certificate of coverage is issued to an individual member of the association or discretionary group.

(b) Notwithstanding section 19 of this chapter, a policy described in subsection (a) may contain a waiver of coverage for a specified condition and complications that arise from the specified condition if:

(1) the period for which the exemption would be in effect does not exceed five (5) years; and

(2) all of the following conditions are met:

(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition, including a specific description of each condition, complication, service, and treatment for which coverage is being waived.

(B) The:

(i) offer of coverage; and

(ii) certificate of coverage;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and specifying each related condition, complication, service, and treatment for which coverage is waived.

(C) The:

(i) offer of coverage; and

(ii) certificate of coverage;

do not include more than two (2) waivers.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage, and any individual to whom the waiver would have applied may apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) The waiver of coverage does not apply to coverage required under state law.

(H) The waiver is included on the list of waivers established by the commissioner under subsection (h).

(c) The insurer shall require an applicant to initial the written notice provided under subsection (b)(2)(A) and the waiver included in the offer of coverage and in the certificate of coverage under subsection (b)(2)(B) to acknowledge acceptance of the waiver of coverage. The initialed written notice must be returned to the insurer before the insurer issues a policy that contains a waiver

under this section.

(d) An insurer shall not, on the basis of a waiver contained in a policy as provided in this section, deny coverage for any condition, complication, service, or treatment that is not specified as required in the:

(1) written notice under subsection (b)(2)(A); and

(2) offer of coverage and certificate of coverage under subsection (b)(2)(B).

(e) An individual who is covered under a policy that includes a waiver under this section may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.

(f) An offer of coverage under a policy that includes a waiver under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.

(g) Notwithstanding subsection (b), a policy described in subsection (a) may not contain a waiver of coverage for a mental health condition.

(h) The commissioner shall adopt rules under IC 4-22-2 to establish a list of waivers, based on a list of diagnostic and procedure codes (as described in IC 27-8-22.1-5(a)(1)), that may be contained in a policy under this section.

(i) A policy that contains a waiver under this section is presumed to provide coverage for a condition, complication, service, or treatment for which coverage is not specifically excluded under:

(1) a waiver under this section; or

(2) the terms of the policy.

SECTION 4. IC 27-8-10-5.1, AS AMENDED BY P.L.233-1999, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 5.1. (a) Except as provided in subsections (b) and (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. **However, an offer of coverage described in IC 27-8-5-2.5(e) or IC 27-8-5-19.2(b) does not affect an individual's eligibility for an association policy under this subsection.** Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(b) Except as provided in IC 27-13-16-4, a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(c) The board of directors may establish procedures that would permit:

(1) an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience; and

(2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.

(d) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full-time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(e) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to

the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(g) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (b), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

SECTION 5. IC 27-8-29-6, AS ADDED BY P.L.203-2001, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a:

(1) grievance filed under IC 27-8-28; **or**

(2) denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2.

SECTION 6. IC 27-8-29-12, AS ADDED BY P.L.203-2001, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2002]: Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding:

(1) an adverse determination of appropriateness;

(2) an adverse determination of medical necessity; ~~or~~

(3) a determination that a proposed service is experimental or investigational; **or**

(4) a denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2;

made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.

SECTION 7. IC 27-8-29-13, AS ADDED BY P.L.66-2001, SECTION 3, AND AS ADDED BY P.L.203-2001, SECTION 14, IS AMENDED AND CORRECTED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's:

(A) appeal resolution under IC 27-8-28-17; **or**

(B) denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2;

not more than forty-five (45) days after the covered individual is notified of the resolution; and

(2) provide for:

(A) an expedited external grievance review for a grievance related to an illness, *a* disease, *a* condition, *an* injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and

(2) rotate the choice of an independent review organization

among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed *for use* by the treating health care provider.

(6) The covered individual requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual may be required to pay not more than twenty-five dollars ($25) of the costs associated with the services of an independent review organization under this chapter. All additional costs must be paid by the insurer.

SECTION 8. [EFFECTIVE JULY 1, 2002] **IC 27-8-5-2.5, as amended by this act, and IC 27-8-5-19.2, as added by this act, apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2002.**

SECTION 9. [EFFECTIVE JULY 1, 2002] **(a) An insurer that issues a policy of accident and sickness insurance that contains a waiver under IC 27-8-5-2.5(e) or IC 27-8-5-19.2, both as added by this act, shall submit to the commissioner of the department of insurance the following information for the reporting periods specified under subsection (b) on a form prescribed by the commissioner:**

(1) The number of policies that the insurer issued with a

waiver.

(2) A list of specified conditions that the insurer waived.

(3) The number of waivers issued for each specified condition listed under subdivision (2).

(4) The number of waivers issued categorized by the period of time for which coverage of a specified condition was waived.

(5) The number of applicants who were denied insurance coverage by the insurer because of a specified condition.

(b) An insurer shall submit the information required under subsection (a) as follows:

(1) Not later than September 1, 2003, for the reporting period July 1, 2002, through June 30, 2003.

(2) Not later than September 1, 2004, for the reporting period July 1, 2003, through June 30, 2004.

(c) The commissioner of the department of insurance shall compile the information submitted under subsection (b) and, not later than November 1, 2004, report the information to the senate health and provider services committee and the house insurance, corporations, and small business committee.

(d) This SECTION expires June 30, 2005.

SECTION 10. [EFFECTIVE JULY 1, 2002] **(a) Notwithstanding IC 27-8-5-2.5(i) and IC 27-8-5-19.2(h), both as added by this act, the commissioner of the department of insurance shall carry out the duties imposed upon the commissioner under IC 27-8-5-2.5(i) and IC 27-8-5-19.2(h), both as added by this act, under interim written guidelines approved by the commissioner of the department of insurance.**

(b) This SECTION expires on the earlier of the following:

(1) The date rules are adopted under IC 27-8-5-2.5(i) and under IC 27-8-5-19.2(h), both as added by this act.

(2) June 30, 2004.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1163, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 4, between lines 7 and 8, begin a new paragraph and insert:

"**(h) Notwithstanding subsection (e), an individual policy of accident and sickness insurance may not contain a waiver of coverage for a mental health condition.**".

Page 4, between lines 11 and 12, begin a new line block indented and insert:

"**(1) that is not employer based;**".

Page 4, line 12, delete "(1)" and insert "**(2)**".

Page 4, line 14, delete "(2)" and insert "**(3)**".

Page 5, between lines 41 and 42, begin a new paragraph and insert:

"**(g) Notwithstanding subsection (b), a policy described in subsection (a) may not contain a waiver of coverage for a mental health condition.**".

Page 10, after line 3, begin a new paragraph and insert:

"SECTION 8. [EFFECTIVE JULY 1, 2002] **(a) An insurer that issues a policy of accident and sickness insurance that contains a waiver under IC 27-8-5-2.5(e) or IC 27-8-5-19.2, both as added by this act, shall submit to the commissioner of the department of insurance the following information for the reporting periods specified under subsection (b) on a form prescribed by the commissioner:**

(1) The number of policies that the insurer issued with a waiver.

(2) A list of specified conditions that the insurer waived.

(3) The number of waivers issued for each specified condition listed under subdivision (2).

(4) The number of waivers issued categorized by the period of time for which coverage of a specified condition was waived.

(5) The number of applicants who were denied insurance coverage by the insurer because of a specified condition.

(b) An insurer shall submit the information required under subsection (a) as follows:

(1) Not later than September 1, 2003, for the reporting period July 1, 2002, through June 30, 2003.

(2) Not later than September 1, 2004, for the reporting period July 1, 2003, through June 30, 2004.

(c) The commissioner of the department of insurance shall

compile the information submitted under subsection (b) and, not later than November 1, 2004, report the information to the senate insurance and financial institutions committee and the house insurance, corporations, and small business committee.

(d) This SECTION expires June 30, 2005.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1163 as introduced.)

CROOKS, Chair

Committee Vote: yeas 13, nays 0.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1163 be amended to read as follows:

Page 3, line 13, after "to" insert "**:**

(i)".

Page 3, line 14, delete "if:" and insert "**one (1) time per year; and**

(ii)".

Page 3, delete lines 15 through 21.

Page 3, line 22, delete "for at least one (1) year, and the insurer agrees to".

Page 5, line 6, after "to" insert "**:**

(i)".

Page 5, line 7, delete "if:" and insert "**one (1) time per year; and**

(ii)".

Page 5, delete lines 8 through 14.

Page 5, line 15, delete "for at least one (1) year, and the insurer agrees to".

(Reference is to HB 1163 as printed January 24, 2002.)

CROOKS

SENATE MOTION

Mr. President: I move that Senator Antich be added as cosponsor of Engrossed House Bill 1163.

JOHNSON

COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1163, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 27-8-5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 1. (a) The term "policy of accident and sickness insurance", as used in this chapter, includes any policy or contract covering one (1) or more of the kinds of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual basis under this section and sections 2 through 9 of this chapter, on the group basis under this section and sections 16 through ~~19~~ **19.2** of this chapter, on the franchise basis under this section and section 11 of this chapter, or on a blanket basis under section 15 of this chapter and (except as otherwise expressly provided in this chapter) shall be exclusively governed by this chapter.

(b) No policy of accident and sickness insurance may be issued or delivered to any person in this state, nor may any application, rider, or endorsement be used in connection with an accident and sickness insurance policy until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been filed with the commissioner. This section is applicable also to assessment companies and fraternal benefit associations or societies.

(c) No policy of accident and sickness insurance may be issued, nor may any application, rider, or endorsement be used in connection with a policy of accident and sickness insurance, until the expiration of thirty (30) days after it has been filed under subsection (b), unless the commissioner gives his written approval to it before the expiration of the thirty (30) day period.

(d) The commissioner may, within thirty (30) days after the filing of any form under subsection (b), disapprove the form:

(1) if, in the case of an individual accident and sickness form, the benefits provided therein are unreasonable in relation to the premium charged; or

(2) if, in the case of an individual, blanket, or group accident and sickness form, it contains a provision or provisions that are unjust, unfair, inequitable, misleading, or deceptive or that encourage misrepresentation of the policy.

(e) If the commissioner notifies the insurer that filed a form that the form does not comply with this section, it is unlawful thereafter for the insurer to issue the form or use it in connection with any policy. In the notice given under this subsection, the commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer.

(f) The commissioner may at any time, after a hearing of which not less than twenty (20) days written notice has been given to the insurer, withdraw his approval of any form filed under subsection (b) on any of the grounds stated in this section. It is unlawful for the insurer to issue the form or use it in connection with any policy after the effective date of the withdrawal of approval. The notice of any hearing called under this subsection must specify the matters to be considered at the hearing, and any decision affirming disapproval or directing withdrawal of approval under this section must be in writing and must specify the reasons for the decision.

(g) Any order or decision of the commissioner under this section is subject to review under IC 4-21.5.".

Page 3, between lines 23 and 24, begin a new line double block indented and insert:

"**(H) The waiver is included on the list of waivers established by the commissioner under subsection (i).**".

Page 3, line 27, after "coverage." insert "**The initialed written notice must be returned to the insurer before the insurer issues a policy that contains a waiver under this section.**".

Page 4, between lines 3 and 4, begin a new paragraph and insert:

"**(i) The commissioner shall adopt rules under IC 4-22-2 to establish a list of waivers, based on a list of diagnostic and procedure codes (as described in IC 27-8-22.1-5(a)(1)), that may be contained in a policy under this section.**

(j) A policy that contains a waiver under this section is presumed to provide coverage for a condition, complication, service, or treatment for which coverage is not specifically excluded under:

(1) a waiver under this section; or

(2) the terms of the policy.".

Page 5, between lines 10 and 11, begin a new line double block indented and insert:

"**(H) The waiver is included on the list of waivers established by the commissioner under subsection (h).**".

Page 5, line 15, after "coverage." insert "**The initialed written notice must be returned to the insurer before the insurer issues a**

policy that contains a waiver under this section.".

Page 5, between lines 34 and 35, begin a new paragraph and insert:

"**(h) The commissioner shall adopt rules under IC 4-22-2 to establish a list of waivers, based on a list of diagnostic and procedure codes (as described in IC 27-8-22.1-5(a)(1)), that may be contained in a policy under this section.**

(i) A policy that contains a waiver under this section is presumed to provide coverage for a condition, complication, service, or treatment for which coverage is not specifically excluded under:

(1) a waiver under this section; or

(2) the terms of the policy.".

Page 10, after line 24, begin a new paragraph and insert:

"SECTION 10. [EFFECTIVE JULY 1, 2002] **(a) Notwithstanding IC 27-8-5-2.5(i) and IC 27-8-5-19.2(h), both as added by this act, the commissioner of the department of insurance shall carry out the duties imposed upon the commissioner under IC 27-8-5-2.5(i) and IC 27-8-5-19.2(h), both as added by this act, under interim written guidelines approved by the commissioner of the department of insurance.**

(b) This SECTION expires on the earlier of the following:

(1) The date rules are adopted under IC 27-8-5-2.5(i) and under IC 27-8-5-19.2(h), both as added by this act.

(2) June 30, 2004.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1163 as reprinted January 30, 2002.)

MILLER, Chairperson

Committee Vote: Yeas 6, Nays 3.

SENATE MOTION

Mr. President: I move that Engrossed House Bill 1163 be amended to read as follows:

Page 12, line 18, delete "insurance and financial institutions" and insert "**health and provider services**".

(Reference is to EHB 1163 as printed February 22, 2002.)

MILLER